GROWTH HORMONE[1] FOR CHILDREN

PRIOR AUTHORIZATION REQUEST FORM

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210
Auburn, AL 36832-3210

PATIENT INFORMATION

Patient name: _____ Patient Medicaid #: _____

Patient DOB: _____ Patient phone # with area code: _____

PRESCRIBER INFORMATION

Prescribing physician: _____ License #: _____

Address: _____ Phone # with area code: _____

City/State/Zip: _____ Fax # with area code: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Physician's signature Date

PHARMACY INFORMATION

Dispensing pharmacy: _____ Provider #: _____

NDC #: _____ J Code: _____ (if applicable) Qty. requested per month: _____

Phone # with area code: _____ Fax # with area code: _____

DRUG/CLINICAL INFORMATION

❒ Initial request ❒ Renewal Drug requested _____ Proposed duration of therapy: _____

Strength/Quantity: _____ Daily dose _____ Height: _____ Weight: _____

Patient must have one of the following primary indications listed below, confirmed by a board certified endocrinologist:

❒ Documented growth hormone deficiency ❒ Turner Syndrome ❒ Growth Deficiency due to Chronic Renal Insufficiency

Diagnostic testing required:

1. Growth Hormone Deficiency[2]: Confirmed with provocative testing and IGF-1 levels: IGF-1 Level: _____ Date: _____
   Provocative Testing: Test 1: type: _____ Result: _____ Date: _____
   Test 2: type: _____ Result: _____ Date: _____
2. Turner Syndrome[3]: Karyotyping: Date _____ Results: _____
3. Chronic Renal Insufficiency: Is the patient currently receiving dialysis? ❒ Yes ❒ No
   GFR: _____ Date: _____
   Growth velocity or height value in standard deviations below the mean _____
4. Is patient's thyroid function normal ❒ Yes ❒ No
5. Is patient's height less than 5th percentile? ❒ Yes ❒ No
6. Has the patient been screened for intracranial malignancy or tumor[4]? ❒ Yes ❒ No (If no, request will be denied)
7. If a history of malignancy exists, has patient been free of recurrence for at least the past 6 months?
   ❒ Yes ❒ No (If no, request will be denied) ❒ No malignancy
8. Does the patient have any of the following contraindications? Check all that apply.
   ❒ Pregnancy ❒ Proliferative or preproliferative diabetic retinopathy ❒ Pseudotumor cerebri or benign intracranial HTN
   ❒ Closed epiphyses (After epiphyseal closure use Adult Growth Hormone Therapy criteria.)

[1] Nutropin AQ®, Nutropin®, Humatrope®, Genotropin®, and Protropin®

[2] As provocative testing, Insulin Tolerance Test is **required** unless contraindicated. ITT is contraindicated in patients with seizures, CAD, abnormal EKG with history of IHD or CV.D If ITT is contraindicated, documentation must be provided and an alternative test performed. Results from other stimulation tests (arginine, glucagon, L-dopa, growth hormone-releasing hormone [GHRH], and combinations of these agents, excluding clonidine), may be submitted for those patients with documented contraindication to ITT. GH peak levels of ≤ 10 ng/ml after provocative testing support GH deficiency and justify treatment.

[3] Short stature in girls with Turner Syndrome is not due to GH deficiency, but growth failure due to an intrinsic skeletal dysplasia. The decision to treat these patients is not based on provocative testing but on the diagnosis of Turner Syndrome using karyotyping.

[4] Children being considered for treatment with growth hormone must be screened prior to initiation of therapy to verify the absence of any malignant condition. If growth failure results from an intracranial tumor, absence of tumor growth or tumor recurrence must be documented for at least 6 months befor initiating growth hormone therapy.

FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments: _____

_____ _____
Reviewer's Signature Response Date/Hour